CERIDIAN
free to be

Flexible Spending Account Reimbursement Form

FAX TO: 1-888-342-5333 FSA Administrative Services **Page 1 of _____**

For faster service, fax this entire sheet, completed and signed, along with the appropriate documentation. Please complete all applicable spaces.

Employee Name: Last	First	Middle Init.	Social Security Number
			— —

Home Address: Number/Street	Apt #	City	State	Zip

Area Code/Telephone #	Company Name	Division/Location	Client Code
	County of Orange		PL1719

Total Health Care Expense(s)	*Total Dep. Care Expense(s)*	Provider's Signature	SSN or Tax I. D. #
$	$	Provider's Address	Date(s) of Service From: _____/_____/_____ To: _____/_____/_____

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee's Signature _____ Date _____

Around the Clock Service for FSA Participants 1-866-300-2303

Once you have enrolled, you have direct access to your healthcare and/or dependent care account 24 hours a day. By accessing our website, www.Ceridian-Benefits.com, or our toll-free automated response system at 1-866-300-2303, you can quickly access your account data and other helpful FSA information. Account data is current as of the previous day's close of business. Customer service professionals are available from 8am to 8pm EST Monday through Friday to assist you.

Important Reminders

- ✓ Only eligible expenses incurred during your FSA plan year and while you are a participant are eligible for reimbursement.
- ✓ An expense is incurred when the service is provided – not when you are billed or pay for the service.
- ✓ Due to the nature of orthodontia and prenatal billing, prepaid expenses for the plan year can be reimbursed before the service is completed.
- ✓ Any unpaid Dependent Care amounts (due to expenses exceeding the amount in your account at the time of the claim) will be paid out automatically as money accumulates in your account. You do not need to resubmit the claim.
- ✓ You will also receive an account summary with each reimbursement in addition to a quarterly account statement.
- ✓ Notify your benefits representative within 30 days if you have an eligible event change and wish to make a corresponding change to your FSA election.
- ✓ You will have a grace period (listed on your FSA Highlights) after the end of the plan year to submit your claims and documentation for expenses incurred during your plan year.
- ✓ You will have a grace period (listed on your FSA Highlights) after any loss of employment to submit your claims and documentation for expenses incurred while you were employed.

Reimbursement Instructions

1. After you have incurred an eligible expense during the plan year, complete a Reimbursement Form. Please note: Health care expenses must be processed first by your primary and secondary (if applicable) health plans.
2. Include the appropriate documentation with a signed reimbursement form:
   Health Care expenses: Send the Explanation of Benefits (EOB) from your insurance company (if you have partial coverage for the expense) or an itemized bill (if you do not). The EOB or bill must contain the actual date of service, the name and address of the provider, a description of the services and the amount charged. You may attach multiple HEALTH CARE receipts to this reimbursement form.
   Dependent Care expenses: Submit your claim in one of the following ways:
   – Complete this reimbursement form containing your provider signature, address, SSN or tax ID #, the date of service, and the amount paid. This completed form serves as your receipt.
   – Or, complete this reimbursement form and submit with a receipt from your provider indicating date of service and amount paid. Provider signature and tax ID is not required when submitting a receipt.
3. **Fax this entire sheet, complete and signed, along with the appropriate documentation to 1-888-342-5333 (Fax)**.
   If you prefer, mail your completed and signed reimbursement form with the documentation attached to:FSA Claims Administration,
   P.O. Box 534055, St. Petersburg, FL 33747-4055. Please keep your original receipts with your tax records, submitting legible copies to Ceridian.
4. Requests for reimbursement received via FAX will be processed the latter of two business days after receipt of the claim or prior to your next scheduled claim reimbursement date. Claims received via mail may require one additional day for processing.
5. Health Care expenses: We will reimburse up to the amount you elected for the year minus any previous reimbursements.
   Dependent Care expenses: We will reimburse up to the amount you have deposited in your account to date (through payroll deductions) minus any previous reimbursements.
6. Follow this process throughout the plan year whenever you have an eligible expense. Be sure to "use up" your entire election... if you don't, you will lose the dollars you have left over (according to IRS regulations).

TPA